PLEASE PRINT

Date:_____/_____/_____ Home Phone: (_____)_____-_____

PATIENT INFORMATION

Name:_____Social Security:_____

Address: _____Cell Phone: (_____)_____-_____

City:_____ State:_____Zip Code:_____

Sex: M [ ] F [ ] Age:_____ Birth Date: _____/_____/_____ Race: _____

Ethnicity:_____ Preferred Language:_____ Blind: [ ] Deaf: [ ]

☐ Married ☐ Widowed ☐ Single ☐ Divorced

☐ Minor ☐ Separated ☐ Partnered for years

Patient Employer/School: _____ Occupation:_____

Employer/School Phone: (_____)_____-_____ E-mail: _____

Whom may we thank for referring you?:_____

Emergency Contact:_____Phone:(_____)_____-_____

PRIMARY INSURANCE

Person Responsible for Account:_____Relation to Patient:_____

Birth Date:_____/_____/_____ Social Security #:_____

Address:_____Phone: (_____)_____-_____

Person Responsible Employed by:_____ Occupation:_____

Business Address:_____Business Phone: (_____)_____-_____

Insurance Company:_____Phone: (_____)_____-_____

Member ID:_____Group:_____Subscriber:_____

Names of other dependents covered under this plan:_____

ADDITIONAL INSURANCE

Is the patient covered by additional insurance? Yes [ ] No [ ]

Person Responsible for Account:_____Relation to Patient:_____

Birth Date:_____/_____/_____Social Security #:_____

Address:_____Phone: (_____)_____-_____

Person Responsible Employed by:_____ Occupation:_____

Insurance Company:_____Phone: (_____)_____-_____

Member ID:_____Group:_____Subscriber:_____

Names of other dependents covered under this plan:_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s) have insurance coverage with _____

Name of Insurance Company(ies)

and assign directly to Dr._____. All insurance benefits, if any, otherwise will be payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature on all insurance submissions.

The above-named physician may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for the related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian, or Personal Representative Relationship to Patient

Confidential Health History

Patient Name:_____Today's Date:_____/_____/_____

Age:_____Birth Date:_____/_____/_____Date of last physical:_____/_____/_____

What is your reason for this visit:_____

SYMPTOMS

Check conditions you currently have or have had in the past year

General

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

Muscle/Joint/Bone

Pain, weakness, numbness in:

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

Genito-Urinary

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

Gastrointestinal

- ☐ Poor appetite
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

Cardiovascular

- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

ENT

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Doubled vision
- ☐ Ear ache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Hearing loss
- ☐ Nose bleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision - flashes
- ☐ Vision - halos

Skin

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sores that won't heal

Men Only

- ☐ Breast lump
- ☐ Erectile dysfunction
- ☐ Lump in testes
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

Women only

- ☐ Abnormal pap smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Menstrual pain
- ☐ Hot flashes
- ☐ Nipples discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last period:

_____/_____/_____

Date of last pap smear:

_____/_____/_____

Date of last mammogram

_____/_____/_____

Are you pregnant? Y N

Number of children:

CONDITIONS

Check the conditions you currently have or have had in the past year

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorders
- ☐ Breast lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chick pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV positive
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Measles
- ☐ Migraine headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate problems
- ☐ Psychiatric Care
- ☐ Rheumatic
- ☐ Scarlet fever
- ☐ Stroke
- ☐ Suicide attempt
- ☐ Thyroid problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid fever
- ☐ Ulcers
- ☐ Vaginal infections
- ☐ Venereal disease

Medications: list medications you are currently taking:

_____ _____ _____

_____ _____ _____

Family History

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check if your blood relatives had any of the following:

Disease	Relationship to you
Arthritis, Gout	
Asthma, Hay Fever	
Cancer	
Chemical Dependency	
Diabetes	
Heart Disease, Stroke	
High Blood Pressure	
Kidney Disease	
Tuberculosis	
Other	

Hospitalizations

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? [ ] Yes [ ] No

If yes, please give approximate dates:_____

Pregnancies

Year of Birth	Sex	Complications if any

Health Habits

Check which you use and how often

- [ ] Caffeine _____
- [ ] Tobacco _____
- [ ] Street Drugs_____
- [ ] Other _____

Serious Illnesses/Injuries

Serious Illnesses/Injuries	Date	Outcome

Occupational

Check if your work exposes you to:

- [ ] Stress
- [ ] Hazardous Substances
- [ ] Heavy Lifting
- [ ] Other:_____

Occupation_____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian, or Personal Representative — Relationship to Patient

Forte Family Practice Health Questionnaire-9 (PHQ-9)

Today's Date:_____/_____/_____

Patient Name:_____Date of Birth:_____/_____/_____

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answer:	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or or hurting yourself in some way	0	1	2	3
For Office Coding: _____+_____+_____+_____ = Total Score: _____				

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display, or distribute.

Forte Family Practice HIPAA Release Form

Patient Name:_____Date of Birth_____/_____/_____

Social Security #:_____Phone: (_____)_____-_____

I authorize the following name(s) of person(s) to have access to my protected health information (PHI). For example, spouse, child, other family members, another physician office, etc.

Authorized parties:

_____ Relation: _____

_____ Relation: _____

_____ Relation: _____

_____ Relation: _____

I do not wish to allow any other party to access my records_____
Initial

I GIVE MY PERMISSION TO RELEASE ANY INFORMATION REGARDING:
(Initial applicable lines below)

_____ Substance Abuse _____Psychiatric/Mental Health _____HIV Info

Forte Family Practice Notice of Privacy Policy is detailed on how my information may be used and disclosed under state and federal law. I may obtain a hard copy of the privacy policy at any time. A copy of this authorization may be used in the place of the original. I understand that I may request restrictions to the Notice of Privacy Policy at any time. I am also aware the Forte Family Practice done not have to agree with restrictions I have requested.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian, or Personal Representative Relationship to Patient

Forte Family Practice Patient Financial Responsibility Disclosure Statement

All charges for services rendered are due and payable at the time of service.

Medical Insurance: We are contracted with most insurance companies, billing the insurance is a service to you. As the responsible party, you are responsible if your insurance company declines to pay for any reason. The person signing on behalf of the patient or the patient's responsible party must:

- Inform Forte Family Practice of the current address and phone number for the patient's responsible party.
- Present all current insurance cards prior to each office visit.
- Verify at each visit that the information is current by signing our data sheet.
- Pay any required copay, co-insurance, and/or deductible at the time of visit.
- Pay an additional amount owed within 30(thirty) days of receiving a statement from our office. (When Forte Family Practice receives an explanation of benefits (EOB) from your insurance company, any amounts that you need to pay will be billed to you).

Returned Check Policy: If a payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF), Account Closed (AC), or Refer to Maker (RTM), the patient or patient's responsible party will be responsible for the original check amount in addition to a $35.00 service charge. Once the notice of the returned check is received, Forte Family Practice will send out a letter to notify the responsible party of the returned check. If a response is not received within 15 days from the letter date by the patient or the responsible party, the account may be turned over to our collection agency and collection fee of 50% will be added to the outstanding balance in addition to the $35.00 check service charge.

Non-Payment on Account: Should collection proceedings or other legal actions become necessary to collect on an overdue account, the patient or the patient's responsible party, understands that Forte Family Practice has the right to disclose information to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The patient or patient's responsible party understands that they are responsible for all costs of collection including, but not limited to, interest due at 8.75% APR, all legal costs, and a collection fee of 10% will be added to the outstanding balance. By signing below, you agree to accept full financial responsibility as a patient who is receiving medical services, or as the responsible party for minor patients.

No Show and Same Day Cancellation Policy: There is a $25.00 no show and same day cancellation fee. Please be aware that insurance will not cover this charge. As a courtesy, it will be your responsibility to cancel or reschedule your appointment with a *24 hour advanced notice.*

Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

Signature of Patient, Parent, Guardian or Personal Representative	Date
Please print name of Patient, Parent, Guardian, or Personal Representative	Relationship to Patient

Forte Family Practice Medical Record Request Form

Patient Information:

Patient Name:_____Date of Birth:_____/_____/_____

Address:_____Social Security #:_____

City:_____State:_____Zip Code:_____Phone: (_____)_____-_____

Obtain Records From:

Provider/Clinic Name:_____

Address:_____City:_____State:_____

Phone: (_____)_____-_____ Fax: (_____)_____-_____

Send Records To (circle one):

9010 West Cheyenne Ave
Las Vegas, Nevada 89129
Phone (702) 240-8646
Fax (702) 240-0206

4845 South Rainbow Blvd
Las Vegas, Nevada 89103
Phone (702) 362-9800
Fax (702) 871-9805

Information To Be Sent:

_____ All Records _____ Other:_____

Reason for Release:

Expiration: This authorization will expire on _____/_____/_____

Revocation: I understand that I may revoke this consent at any time. I do not authorize further release to any third party. I understand that once information is released under this authorization, the clinic, the employees, and my physician cannot prevent the disclosure of that information.

Authorization: I authorization for the above provider to release the information marked above to the recipient.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative | Date

_____ _____
Please print name of Patient, Parent, Guardian, or Personal Representative | Relationship to Patient

Forte Family Practice Prescription Refill Request Agreement

Patient Name:_____Date of Birth:_____/_____/_____

Pharmacy Name:_____

Pharmacy Address/Cross Streets:_____

Pharmacy Phone: (_____)_____-_____ Pharmacy Fax: (_____)_____-_____

This is to acknowledge that:

_____ This office does not accept automatic refill requests sent by my pharmacy.

_____ This office makes every effort to ensure that I have adequate quantity of prescription medications until my next scheduled office visit.

_____ I will make every effort to keep my scheduled appointments.

_____ If I miss or cancel my appointment, I will contact this office to provide the name and dose of my medications along with the contact information of my designated pharmacy. More importantly, I will schedule a new appointment and my medications will be reviewed for refill authorization up to my scheduled office visit.

_____ It may take up to 4 business days for this office to respond to my request for refill.

_____ I will not wait until I run our of medications before calling the office for my refill request.

_____ I understand that any controlled substance prescriptions can only be written at an appointment.

_____ I am fully informed about the conditions of requesting refills for my prescriptions.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative | Date

_____ _____

Please print name of Patient, Parent, Guardian, or Personal Representative | Relationship to Patient

Patient Consent Form for Electronic Exchange of Individual Health Information

HealtHIE Nevada is a non-profit organization dedicated to connecting the healthcare community to share information electronically and securely to improve the quality of healthcare services. To learn more about the Health Information Exchange (HIE), read the Patient Information brochure. You can ask the doctor that gave you this form for it, or go to the website www.healtHIEnevada.org.

Details about patient information in HealtHIE Nevada and the consent process:

1. **How your information will be used and who can access it:** When you provide consent, only HealtHIE Nevada participants (such as doctors, hospitals, laboratories, radiology centers, and pharmacies), will have access to your health information. It can only be used to:

   - Provide you with medical treatment and related services.
   - Evaluate and improve the quality of medical care provided to all patients, using de-identified health information.

2. **Types of information included and where it comes from:** The information about you comes from organizations that have provided you with medical care, and are HealtHIE Nevada participants. These may include hospitals, physicians, pharmacies, clinical laboratories, and other healthcare organizations. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medications your doctor has prescribed. This may include information created before the date of this Consent Form. This information may relate to sensitive health conditions, including but not limited to:

   - Alcohol or drug use problems
   - HIV/AIDS
   - Birth control and abortion (family planning)
   - Genetic (inherited) diseases or tests
   - Mental Health conditions
   - Sexually transmitted diseases

3. **Improper Access or Disclosure of your Information:** Electronic information about you may be disclosed by a participating doctor to others only to the extent permitted by Nevada State Law. If at any time you suspect that someone who should not have seen or received information about you has done so, you should notify your doctor.

4. **Effective Period:** Your consent becomes effective upon signing this form and will remain in effect until the day you revoke it or HealtHIE Nevada ceases to conduct business.

5. **Revoking your consent:** At any time, you may revoke your consent by signing a new consent form and giving it to your doctor. These forms are available at your doctor's office, or by calling 855-484-3443. Changes to your consent status may take 24-48 hours to become active in the system.

   Note: Organizations that access your health information through HealtHIE Nevada while your consent is in effect may copy or include your information into their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.

6. **How your information is protected:** Federal and State laws and regulations protect your medical information. HIPAA, the Healthcare Insurance Portability and Accountability Act of 1996, is the federal law that protects your medical records and limits who can look at and receive your health information, including electronic health information. HIPAA's protections were further strengthened by another federal law, the HITECH Act of 2009, which may impose severe financial fines on anyone who violates your medical privacy rights. All health information made available on the HIE, including your medical information, is encrypted to federal standards and is accessible only as allowed by Nevada State law (NRS 439.590). In addition, your doctor must provide you with a Notice of Privacy Practices, which describes how he or she uses and protects your medical information.

Copy of Form: You are entitled to receive a copy of this Consent Form after you sign it.

Patient Consent Form for Electronic Exchange of Individual Health Information

Please read through the consent form and provide the following information: (Please Print)

PATIENT NAME_____
Last *First* *Middle*

PREVIOUS NAME(S)_____ **GENDER:** M_____F_____

STREET ADDRESS / P.O. BOX_____

CITY_____**STATE**_____**ZIP CODE**_____

PHONE NUMBER_____ **EMAIL**_____

DATE OF BIRTH_____(MM)_____(DD)_____(YYYY)

☐ **Nevada Medicaid Patients Please Read:** Nevada law mandates that "a person who is a recipient of Medicaid or insurance pursuant to the Children's Health Insurance Program may not opt out of having his or her individually identifiable health information disclosed electronically" (NRS 439.539). When a patient is no longer a Medicaid recipient, it is the patient's responsibility to change their consent choice, if they choose to do so. Please sign below to indicate your acknowledgment.

Consent Choices: (CHECK ONE) Nevada Medicaid Patients are exempt from making a selection.
Your choice to give or to deny consent may not be the basis for denial of health services.

☐ **I CONSENT** for all HIE participants to access **ALL** of my electronic health information (including sensitive information) in connection with providing me any health care services, including emergency care.

☐ **I CONSENT ONLY IN CASE OF AN EMERGENCY** for all HIE participants to access **ALL** of my electronic health information (including sensitive information) **ONLY** in the event of a medical emergency.

☐ **I DO NOT CONSENT** for any HIE participants to access **ANY** of my electronic health information **EVEN** in the event of a medical emergency.

_____ _____
Signature of patient or authorized representative **Date** **Time**

If I sign this form as the Patient's Authorized Representative, I understand that all references in this form to "I", "me" or "my" refer to the Patient.

_____ _____ _____
Name of Authorized Representive (Printed) Relationship Date Time

_____
Address of authorized representative signing this form (please print):

_____
Phone number of authorized representative

FOR INTERNAL USE ONLY
Name of Organization:_____Forte Family Practice_____ Name of Witness:_____
As a witness to this Consent, I attest that the above signer is personally known to me or has established his/her identity with me by satisfactory photo ID, insurance card, or other evidence of identity customarily replied upon in health care.